COMMISSION PROCEEDINGS

The Joint Study Committee on Infection Control and Disclosure met 4 times during the 2008-2009 interim. The Joint Study Committee on Infection Control and Disclosure heard from the individuals listed below during the meeting. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

September 16, 2008

- Shawn Parker, Legislative Analyst, Research Division, provided the committee with an overview of healthcare associated infection collection and reporting initiatives by states.

- Ben Popkin, Staff Attorney, Research Division, presented observations and recommendations of the Healthcare Infection Control Practices Advisory Committee.

October 13, 2008

- Carol Koeble, Director, North Carolina Center for Hospital Quality and Patient Safety and Joanne Campione, Clinical Measurement Services, North Carolina Center for Hospital Quality and Patient Safety, gave a presentation on current initiatives focused on preventing infections in North Carolina hospitals.

- Ben Popkin, Staff Attorney, Research Division, summarized the findings from the 2005 North Carolina hospital survey on public reporting of healthcare associated infections and discussed components necessary for legislation on the public reporting of healthcare associated infections.

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November 18, 2008

- William Cramer, Director of Healthcare Associated Infection Prevention, Pennsylvania Department of Health, gave a presentation on Pennsylvania's experience with reporting on healthcare associated infections.

January 22, 2009

- Ben Popkin, Staff Attorney, Research Division, presented a draft final committee report to the committee for their review and approval. The committee discussed the report, including the proposed surveillance and reporting methodology, recommendations, and legislation, voting to approve the report as amended in committee. The adopted proposal calls for an incremental approach to be taken by dedicated staff in the DHHS, Division of Public Health, beginning with reporting of Central Line-Associated Bloodstream Infections (CLABSI) and expanding to include additional process and outcome measures as appropriate.